DELTA HEALTH SYSTEMS

www.deltahealthsystems.com

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SUBSCRIBER ID NUMBER

☐☐☐ - ☐☐ - ☐☐☐☐

COUNTY OF ORANGE DENTAL CLAIM FORM

PATIENT AND SUBSCRIBER INFORMATION

1. PATIENT'S NAME	2. PATIENT'S DATE OF BIRTH	3. SUBSCRIBER'S NAME
	| |	
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE ☐ FEMALE ☐ 7. PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	6. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) ☐ CHECK HERE IF NEW ADDRESS

8. OTHER HEALTH INSURANCE COVERAGE
IS PATIENT COVERED BY ANY OTHER PLAN? ☐ YES ☐ NO IF YES, PROVIDE NAME AND ADDRESS OF CARRIER:

IDENTIFICATION OR SOCIAL SECURITY NUMBER _____ NAME OF EMPLOYER _____

TYPES OF COVERAGE BY CARRIER: ☐ MEDICAL ☐ DRUG ☐ DENTAL ☐ VISION

EFFECTIVE DATE OF COVERAGE _____ TERMINATION DATE OF COVERAGE _____

9. I AUTHORIZE THE UNDERSIGNED DENTIST TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.	10. I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO UNDERSIGNED DENTIST OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW.
SIGNED (SUBSCRIBER OR PATIENT) _____ DATE _____	SIGNED (SUBSCRIBER OR PATIENT) _____ DATE _____

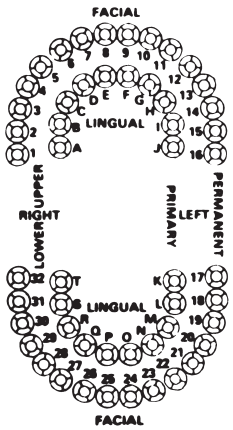
DENTIST'S INFORMATION

11. DENTIST OR GROUP NAME			19. IS TREATMENT RESULT OF OCCUPTIONAL ILLNESS OF INJURY?	NO ☐	YES ☐	IF YES, ENTER BRIEF DESCRIPTION AND DATES
12. MAILING ADDRESS			20. IS TREATMENT RESULT OF AUTO ACCIDENT?	☐	☐	
CITY STATE ZIP			21. OTHER ACCIDENT?	☐	☐	
			22. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	☐	☐	
13. SOC. SEC. OR T.I. NO.	14. TAXABLE ENTITY NAME (IF DIFFENENT THAN BOX 11)	15. DENTIST PHONE NO.	23. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	☐	☐	(IF NO, REASON FOR REPLACEMENT) 24. DATE OF PRIOR PLACEMENT
16. FIRST VISIT DATE CURRENT SERIES	17. PLACE OF TREATMENT OFFICE ; HOSP. ; ECF ; OTHER	18. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ HOW MANY?	25. IS TREATMENT FOR ORTHODONTICS?	☐	☐	IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

TO THE DENTIST: PREDETERMINATION OF BENEFITS REQUIRED FOR CLAIMS IN EXCESS OF $1,200.00

CHECK ONE: ☐ DENTIST'S PRE-TREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

IDENTIFY MISSING TEETH WITH "X"



27. REMARKS FOR UNUSUAL SERVICES

26. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER		FEE	
		X-RAY REQUIRED FOR MAJOR							
		WORK EXCEPT PERIODONTAL							
		AND ENDODONTIC							
		PERIODONTAL SERVICES							
		REQUIRE PERIO-CHART.							

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

SIGNED (DENTIST) DATE

TOTAL FEE CHARGED

FORM NO. 105 REV. 12/00

(G-09)